VENDOR PAYMENT REQUEST

(for amounts $500 and over)

(Revised 12-17-15)

(includes bills for expert fees, depositions, medical review and consultation, court reporters, investigators, mediators, life planners, outside copy charges, etc.)

Case Name _____ v. _____
Plaintiff **Defendant(s)/HCP you are representing**

Invoice # _____ Date of invoice _____ HCSF No. _____

Type of Service: _____
(e.g. court reporter, expert witness, mediation, copy charge, etc.)

Vendor Name _____ TIN or SSN: _____
Note: *(If you have not previously submitted an invoice for this vendor, please provide a W-9.Vendor name must match with TIN or SSN on file with IRS)*

Vendor Address _____

Address check to be mailed to if different from above:
_____

Date(s) of service *(must show on invoice)* **_____**

Amount being requested _____ Vendor hourly rate(s) if appl. _____

Your billing contact information: Name_____

Phone _____ Fax _____ Email _____

Special Instructions:

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For HCSF Use Only: (Authorized by: _____) (Date: _____)

Total Amount Requested: $_____ Case No: _____ Case Letter: _____

_____	_____	_____	_____
Defendant ( )	**Defendant ( )**	**Defendant ( )**	**Defendant ( )**
$_____	**$_____**	**$ _____**	**$_____**

____ KU Foundation **_____KU Residency** **_____WCGME**